

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0042077</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Alden of Old Town West</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>118 S Bloomingdale</u> <u>Bloomingdale</u> <u>60108</u>																									
Number City Zip Code																									
County: <u>Dupage</u>																									
Telephone Number: <u>(630) 671-1660</u> Fax # <u>(630) 671-0457</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Derek Smart</u></td></tr><tr><td>(Title) <u>CFO, Alden Management Services, Inc., as agent</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>773-286-3883</u> Fax # <u>773-286-8038</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Derek Smart</u>	(Title) <u>CFO, Alden Management Services, Inc., as agent</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>773-286-3883</u> Fax # <u>773-286-8038</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Derek Smart</u>																								
	(Title) <u>CFO, Alden Management Services, Inc., as agent</u>																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>773-286-3883</u> Fax # <u>773-286-8038</u>																								
Date of Initial License for Current Owners: <u>05/19/98</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☒ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Mark Novotny</u> Telephone Number: <u>773-724-6362</u>																									
Email Address: _____																									

Facility Name & ID Number Alden of Old Town West

0042077 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)		0	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF				
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS	5,854			5,854
14	TOTALS	5,854			5,854

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.97%

D. How many bed reserve days during this year were paid by the Department? 2 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 5/19/98

J. Was the facility purchased or leased after January 1, 1978? YES Date NO X

K. Was the facility certified for Medicare during the reporting year? YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL X CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	89,885	2,491	4,909	97,285	106	97,391	(1,990)	95,401			1
2	Food Purchase		51,220		51,220	(8,607)	42,613	909	43,522			2
3	Housekeeping	46,884	8,334		55,218		55,218	2,042	57,260			3
4	Laundry		6,534		6,534		6,534		6,534			4
5	Heat and Other Utilities			20,607	20,607		20,607	305	20,912			5
6	Maintenance			44,634	44,634		44,634	11,325	55,959			6
7	Other (specify):* related party / Security			300	300		300	946	1,246			7
8	TOTAL General Services	136,769	68,579	70,450	275,798	(8,501)	267,297	13,537	280,834			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	585,670	45,892	384	631,946	674	632,620	5,829	638,449			10
10a	Therapy			3,973	3,973		3,973	987	4,960			10a
11	Activities	23,259	28	1,193	24,480		24,480		24,480			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* related party							815	815			15
16	TOTAL Health Care and Programs	608,929	45,920	9,150	663,999	674	664,673	7,631	672,304			16
	C. General Administration											
17	Administrative							25,013	25,013			17
18	Directors Fees											18
19	Professional Services			119,859	119,859		119,859	(90,984)	28,875			19
20	Dues, Fees, Subscriptions & Promotions			2,709	2,709		2,709	(665)	2,044			20
21	Clerical & General Office Expenses	46,191	834	26,821	73,846		73,846	32,629	106,475			21
22	Employee Benefits & Payroll Taxes			126,109	126,109	7,793	133,902	(101)	133,801			22
23	Inservice Training & Education											23
24	Travel and Seminar			149	149		149	125	274			24
25	Other Admin. Staff Transportation			742	742		742	1,115	1,857			25
26	Insurance-Prop.Liab.Malpractice			44,153	44,153		44,153	1,760	45,913			26
27	Other (specify):* related party			691	691		691	9,225	9,916			27
28	TOTAL General Administration	46,191	834	321,233	368,258	7,793	376,051	(21,883)	354,168			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	791,889	115,333	400,833	1,308,055	(34)	1,308,021	(715)	1,307,306			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,314	8,314		8,314	38,571	46,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,554	6,554		6,554	28,295	34,849			32
33	Real Estate Taxes			17,744	17,744	(17,744)		17,389	17,389			33
34	Rent-Facility & Grounds			74,999	74,999	17,744	92,743	(92,743)				34
35	Rent-Equipment & Vehicles			1,394	1,394		1,394	4,473	5,867			35
36	Other (specify):* MIP							5,142	5,142			36
37	TOTAL Ownership			109,005	109,005		109,005	1,127	110,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,071		8,071	34	8,105	(2,531)	5,574			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			89,778	89,778		89,778		89,778			42
43	Other (specify):* Day Training			354,568	354,568		354,568		354,568			43
44	TOTAL Special Cost Centers		8,071	444,346	452,417	34	452,451	(2,531)	449,920			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	791,889	123,404	954,184	1,869,477		1,869,477	(2,119)	1,867,358			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Alden of Old Town West
Period Beginning: 1/1/2020
Period Ending: 12/31/2020

IDPH License No. 0042077

Reclassifications - Pages 3 & 4 (Column 5)

From Line	To Line	Amount	Description
2	22	(8,607.00) 8,607.00	Employee Meals Employee Meals
22	1	(814.00) 106.00	Uniform Reclass Uniform Reclass
	3		Uniform Reclass
	4		Uniform Reclass
	6		Uniform Reclass
	10	708.00	Uniform Reclass
	11		Uniform Reclass
	21		Uniform Reclass
10	39	(34.00) 34.00	Oxygen Cost Reclass Oxygen Cost Reclass
33	34	(17,744.00) 17,744.00	Rent - Real Estate Tax on associated landowner (Pg 6) Rent - Real Estate Tax on associated landowner (Pg 6)
		-	

Note for internal purposes: check your reclasses on last year's file, as there may be reclasses specific to your facility.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,254)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,687)	21		17
18	Fines and Penalties				18
19	Entertainment	(30)	20		19
20	Contributions	(330)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(691)	27		24
25	Fund Raising, Advertising and Promotional	(453)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,445)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,783		34
35	Other- Attach Schedule	543		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,326		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,119)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Late Fees on Utilities	(116)	5	2
3	Intercompany Interest	(6,539)	32	3
4	Elim Deprec Exp on Pg 12 items under \$2,500	(1,160)	30	4
5	Elim Deprec Exp on Pg13 items under \$2,500	(5,158)	30	5
6	Expense Pg 12 items under \$2,500 - curr yr purchs	2,197	6	6
7	Expense Pg 13 items under \$2,500 - curr yr purchs	11,403	6	7
8				8
9	Reconcile Depreciation expense	(81)	30	9
10	Elim ABC Deprec Exp from Pg 12 Series	(3)	30	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	543		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(1,990)	0	0	0	0	0	0	0	(1,990)	1
2	Food Purchase	0	0	0	909	0	0	0	0	0	0	0	909	2
3	Housekeeping	0	0	2,042	0	0	0	0	0	0	0	0	2,042	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(116)	0	421	0	0	0	0	0	0	0	0	305	5
6	Maintenance	8,346	0	2,914	0	0	0	11	54	0	0	0	11,325	6
7	Other (specify):*	0	0	946	0	0	0	0	0	0	0	0	946	7
8	TOTAL General Services	8,230	0	6,323	(1,081)	0	0	11	54	0	0	0	13,537	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	5,541	456	(168)	0	0	0	0	0	0	5,829	10
10a	Therapy	0	0	0	0	0	987	0	0	0	0	0	987	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	815	0	0	0	0	0	0	0	0	815	15
16	TOTAL Health Care and Programs	0	0	6,356	456	(168)	987	0	0	0	0	0	7,631	16
	C. General Administration													
17	Administrative	0	0	25,013	0	0	0	0	0	0	0	0	25,013	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,050	(95,034)	0	0	0	0	0	0	0	0	(90,984)	19
20	Fees, Subscriptions & Promotions	(813)	0	148	0	0	0	0	0	0	0	0	(665)	20
21	Clerical & General Office Expenses	(1,687)	0	34,316	0	0	0	0	0	0	0	0	32,629	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(101)	0	0	0	0	0	0	(101)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	125	0	0	0	0	0	0	0	0	125	24
25	Other Admin. Staff Transportation	0	0	1,115	0	0	0	0	0	0	0	0	1,115	25
26	Insurance-Prop.Liab.Malpractice	0	1,719	41	0	0	0	0	0	0	0	0	1,760	26
27	Other (specify):*	(691)	10	9,906	0	0	0	0	0	0	0	0	9,225	27
28	TOTAL General Administration	(3,191)	5,779	(24,370)	0	(101)	0	0	0	0	0	0	(21,883)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	5,039	5,779	(11,691)	(625)	(269)	987	11	54	0	0	0	(715)	29

STATE OF ILLINOIS

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,402)	33,855	11,118	0	0	0	0	0	0	0	0	38,571	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,539)	27,307	7,527	0	0	0	0	0	0	0	0	28,295	32
33	Real Estate Taxes	0	16,548	841	0	0	0	0	0	0	0	0	17,389	33
34	Rent-Facility & Grounds	0	(92,743)	0	0	0	0	0	0	0	0	0	(92,743)	34
35	Rent-Equipment & Vehicles	0	0	4,473	0	0	0	0	0	0	0	0	4,473	35
36	Other (specify):*	0	5,142	0	0	0	0	0	0	0	0	0	5,142	36
37	TOTAL Ownership	(12,941)	(9,891)	23,959	0	0	0	0	0	0	0	0	1,127	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(2,460)	(71)	0	0	0	0	0	0	(2,531)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(2,460)	(71)	0	0	0	0	0	0	(2,531)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(7,902)	(4,112)	12,268	(3,085)	(340)	987	11	54	0	0	0	(2,119)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group, Ltd.	100	See PG-Supp		See PG-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 92,743	Alden of Bloomingdale Limited Partnership	0.00 %	\$	\$ (92,743)	1
2	V	32	Interest Income - Rep Reserve	4	Alden of Bloomingdale Limited Partnership			(4)	2
3	V	19	Accounting Fees		Alden of Bloomingdale Limited Partnership		4,050	4,050	3
4	V	19	Legal Fees: Non-Collections		Alden of Bloomingdale Limited Partnership				4
5	V	19	Professional Fees		Alden of Bloomingdale Limited Partnership				5
6	V	21	Corporate Annual Report Fees		Alden of Bloomingdale Limited Partnership				6
7	V	33	Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		16,548	16,548	7
8	V	26	General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,719	1,719	8
9	V	36	Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		5,142	5,142	9
10	V	32	Interest-Mortgage		Alden of Bloomingdale Limited Partnership		25,709	25,709	10
11	V	30	Depreciation Expense		Alden of Bloomingdale Limited Partnership		33,855	33,855	11
12	V	32	Amortization Expense		Alden of Bloomingdale Limited Partnership		1,602	1,602	12
13	V	27	Income Tax Expense		Alden of Bloomingdale Limited Partnership		10	10	13
14	Total			\$ 92,747			\$ 88,635	\$ * (4,112)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 421	\$ 421	15
16	V	24	Travel & Seminar		Alden Management Services, Inc.		125	125	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,115	1,115	17
18	V	26	Insurance		Alden Management Services, Inc.		41	41	18
19	V	20	Dues & Subscriptions		Alden Management Services, Inc.		148	148	19
20	V	30	Depreciation		Alden Management Services, Inc.		11,118	11,118	20
21	V	33	Real Estate Taxes		Alden Management Services, Inc.		841	841	21
22	V	35	Rent-Equipment & Vehicles		Alden Management Services, Inc.		4,473	4,473	22
23	V	32	Interest		Alden Management Services, Inc.		7,527	7,527	23
24	V	3	Housekeeping		Alden Management Services, Inc.		2,042	2,042	24
25	V	7	Employee Benefits - Gen'l Services		Alden Management Services, Inc.		946	946	25
26	V	10	Nursing & Medical Record Salaries		Alden Management Services, Inc.		5,541	5,541	26
27	V	15	Employee Benefits - Health Care		Alden Management Services, Inc.		815	815	27
28	V	17	Administrative Salary		Alden Management Services, Inc.		25,013	25,013	28
29	V	27	Employee Benefits - Admin		Alden Management Services, Inc.		9,906	9,906	29
30	V	19	Professional Fees	115,570	Alden Management Services, Inc.		20,536	(95,034)	30
31	V	21	General & Administrative	6,960	Alden Management Services, Inc.		41,276	34,316	31
32	V	6	Repairs & Maintenance	4,096	Alden Management Services, Inc.		7,010	2,914	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 126,626			\$ 138,894	\$ * 12,268	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Consult.	\$ 4,909	Prism Health Care Services, Inc.	0.00%	\$	(4,909)	15
16	V	1	Dietary Salary		Prism Health Care Services, Inc.		2,760	2,760	16
17	V	2	Tube feeding	59	Prism Health Care Services, Inc.		483	424	17
18	V	10	Equip. Rental	360	Prism Health Care Services, Inc.		673	313	18
19	V	39	Ancillary supplies	4,550	Prism Health Care Services, Inc.		1,210	(3,340)	19
20	V	1	Gen'l & Admin & benefits		Prism Health Care Services, Inc.		159	159	20
21	V	2	Gen'l & Admin & benefits		Prism Health Care Services, Inc.		485	485	21
22	V	10	Gen'l & Admin & benefits		Prism Health Care Services, Inc.		143	143	22
23	V	39	Gen'l & Admin & benefits		Prism Health Care Services, Inc.		880	880	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 9,878			\$ 6,793	\$ * (3,085)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	39 Drugs	\$ 3,491	Forum Extended Care II, Inc.	0.00%	\$ 3,325	\$ (166)	15
16	V	39 I.V.		Forum Extended Care II, Inc.				16
17	V	39 Wound Care-Product only	30	Forum Extended Care II, Inc.		29	(1)	17
18	V	10 House Stock	3,161	Forum Extended Care II, Inc.		3,011	(150)	18
19	V	10 Pharm Consult	384	Forum Extended Care II, Inc.		366	(18)	19
20	V	22 Employee Vaccinations	101	Forum Extended Care II, Inc.			(101)	20
21	V	39 Employee Vaccinations		Forum Extended Care II, Inc.		96	96	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 7,167			\$ 6,827	\$ * (340)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Therapy	\$ 3,973	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 4,960	\$ 987	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 3,973			\$ 4,960	\$ * 987	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$ 4,624	Alden Bennett Construction Company, Inc.	0.00%	\$ 4,635	\$ 11	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,624			\$ 4,635	\$ * 11	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$ 58	Alden Design Group, Ltd.	0.00%	\$ 112	\$ 54	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 58			\$ 112	\$ * 54	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Alden of Old Town West

0042077

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	The Alden Group, Ltd.	100	Heather Health Care Center, Inc.	Harvey	The Forum Professional	Chicago	Rental property	1
2			Alden-Lincoln Park Rehabilitation and Health Care Center	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Care Center	Chicago	Forum Extended Care	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care Center	Chicago	FECS of Central Illinois	Springfield	Pharmacy	4
5			Alden of Old Town East, Inc.	Bloomington	Alden Management Services	Chicago	Management	5
6			Alden Terrace of McHenry Rehabilitation and Health Care Center	McHenry				6
7			Wentworth Rehabilitation and Health Care Center	Chicago	Alden Garden Courts of	DesPlaines	Assisted Living/Alzheimer's	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Water	Aurora	SNF & Alzheimer's	8
9			Alden - Valley Ridge Rehabilitation and Health Care Center	Bloomington	Alden Gardens of Water	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Youth	Bloomington	Prism Health Care Services	Schaumburg	Nursing and durable medical equipment	10
11			Alden - Orland Park Rehabilitation and Health Care Center	Orland Park	Community Physical Therapy	Addison	Therapy Provider	11
12			Princeton Rehabilitation and Health Care Center	Chicago	Alden Bennett Construction	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomington	Fort Medical Equipment	Fort Atkinson	Nursing and durable medical equipment	13
14			Alden - Town Manor Rehabilitation and Health Care Center	Cicero	Alden Design Group, Inc.	Chicago	Design & Engineering	14
15			Alden Trails, Inc.	Bloomington				15
16			Alden - Poplar Creek Rehabilitation and Health Care Center	Hoffman Estates	Family Solutions for Senior Living	Addison	Private duty care	16
17			Alden - North Shore Rehabilitation and Health Care Center	Skokie	Family Home Health Services	Addison	Home health & hospice	17
18			Alden - Des Plaines Rehabilitation and Health Care Center	Des Plaines				18
19			Alden Estates of Evanston, Inc.	Evanston				19
20			Alden - Alma Nelson Manor, Inc.	Rockford				20
21			Alden - Park Strathmoor, Inc.	Rockford				21
22			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				22
23			Alden Estates of Barrington, Inc.	Barrington				23
24			Alden of Waterford, LLC	Aurora				24
25			Alden Springs, Inc.	Bloomington				25
26			Alden Village North, Inc.	Chicago	Alden Courts of Shorewood	Shorewood	SNF	26
27			Alden Estates of Skokie, Inc.	Skokie	Alden Estates-Courts of	Huntley	SNF	27
28			Alden Estates of Countryside, Inc.	Jefferson, WI				28
29			Alden Estates of Shorewood, Inc.	Shorewood, IL				29
30			Alden - Long Grove Rehabilitation and Health Care Center	Long Grove				30

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg A.	Chairman-Board of I	Chairman	100.00	184,104	0.192	0.48	Salary	\$ 896	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	99,516	0.192	0.48	Salary	484	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	99,516	0.192	0.48	Salary	484	6-7	3
4	Ina Schlossberg D.	Board Member	Board member	0.00	113,260	0.192	0.48	Salary	551	17-7	4
5	Audra Elisco F.	Medical Records Cle	Medical records	0.00	63,136	0.192	0.48	Salary	307	21-7	5
6	Randi Schlossberg-Schullo F.	President	General Operation	0.00	184,104	0.168	0.48	Salary	896	6-7, 17-7	6
7	A. Floyd Schlossberg is the Chairman of the Board of Directors, Alden Management Services, Inc.										7
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg.										8
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg.										9
10	D. Ina Schlossberg is the wife of Floyd Schlossberg.										10
11	E. Audra Elisco is the daughter of Floyd Schlossberg.										11
12	F. Randi Schlossberg-Schullo is the daughter of Floyd Schlossberg.										12
13								TOTAL	\$ 3,618		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Alden of Old Town West# 0042077 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773-286-3883
 Fax Number (773-286-8038

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,209,117	36	\$ 86,976	\$	5,854	\$ 421	1
2	24	Trav & Seminar	Patient Days	1,209,117	36	25,753		5,854	125	2
3	25	Other Admin Travel	Patient Days	1,209,117	36	230,320		5,854	1,115	3
4	26	Insurance	Patient Days	1,209,117	36	8,433		5,854	41	4
5	20	Dues & Subscriptions	Patient Days	1,209,117	36	30,557		5,854	148	5
6	30	Depreciation	No of Providers/usage	36	36	408,834		1	11,118	6
7	33	Real Estate Tax	Patient Days/usage	1,209,117	36	200,354		5,854	841	7
8	35	Rent-Equip & Vehicle	Patient Days	1,209,117	36	923,790		5,854	4,473	8
9	32	Interest	Patient Days/usage	1,209,117	36	1,567,343		5,854	7,527	9
10	3	Housekeeping Salary	Patient Days	1,209,117	36	421,760	421,760	5,854	2,042	10
11	7	Employee Benefits -Gen'I Servs	Patient Days	1,209,117	36	195,292		5,854	946	11
12	10	Nurs & Med Records Salary	Patient Days	1,209,117	36	1,149,694	1,149,694	5,854	5,541	12
13	15	Employee Benefits -Health Care	Patient Days	1,209,117	36	168,303		5,854	815	13
14	17	Administrative Salary	Patient Days/usage	1,209,117	36	5,264,790	5,264,790	5,854	25,013	14
15	27	Employee Benefits - Admin	Patient Days	1,209,117	36	2,046,057		5,854	9,906	15
16	19	Professional fees	Patient Days	1,209,117	36	1,372,458	1,094,350	5,854	20,536	16
17	21	Gen'I & Admin	Patient Days	1,209,117	36	8,525,354	7,617,708	5,854	41,276	17
18	6	Repair & Maint.	Patient Days	1,209,117	36	1,379,344	912,301	5,854	7,010	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 24,005,407	\$ 16,460,603		\$ 138,894	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Cambridge (GL 7055)		X	Mortgage	\$6,317.00	9/1/12	\$ 1,212,967	\$ 1,016,380	12/31/47	2.5000	\$ 25,709	1
2												2
3												3
4	Amort of Fin Fees (GL7105)		X	Refinancing							1,602	4
5	Insurance Interest (GL 7035)		X	Medical Malpractice							15	5
	Working Capital											
6	Related party - AMS		x	Working capital							7,527	6
7												7
8												8
9	TOTAL Facility Related				\$6,317.00		\$ 1,212,967	\$ 1,016,380			\$ 34,853	9
	B. Non-Facility Related*											
10	Interest Income on R.R.		x								(4)	10
11	Interest Income (GL 4975)		x									11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (4)	14
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,016,380			\$ 34,849	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,142 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.		\$	18,205	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	16,828	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,377)	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	17,925	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	16,548	7	
Real Estate Tax History:		Plus: Related party taxes - See Pg RE_Tax page		\$	841
		Total Real Estate Tax Expense, Sch V, Line 33		\$	17,389
Real Estate Tax Bill for Calendar Year:		2015	16,847	8	
		2016	17,039	9	
		2017	17,622	10	
		2018	17,616	11	
		2019	16,828	12	
The current year accrual is based on an estimated 3% increase of the prior year tax.				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden of Old Town West COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0042077

CONTACT PERSON REGARDING THIS REPORT Mark Novotny

TELEPHONE 773-724-6362 FAX #: 872-469-1725

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. See attached (Supplement)	Related party - Alden Management	\$ 173,696.00	\$ 841.00
2. 02-15-112-007	Nursing Home Facility	\$ 16,828.12	\$ 16,828.12
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 190,524.12	\$ 17,669.12

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848

B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing home facility	18,000	1995	\$ 150,868	1
2					2
3	TOTALS	18,000		\$ 150,868	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1998	1998	\$ 934,861	\$ 23,372	40	\$ 23,372		\$ 503,117
5										
6										
7										
8										
	Improvement Type**									
9	Sprinkler system			1999	1,510		15			1,510
10	ABC-counter tops			2004	8,102		10			8,102
11	ABC-Installed Dining Room Flooring			2005	5,421	361	15	361		5,421
12	ABC-Kitchen Repairs			2005	6,146	410	15	410		6,146
13										
14	Kitchen work(cabinetry,floor repair,wall repair & paint) - ABC			2011	11,117	556	20	556		5,421
15	Valve sprinkler/fire & replace ball valve - USFIRE			2011	4,190		5			4,190
16										
17	USFIRE - Repair fire safety equipment			2012	4,785	479	10	479		4,111
18										
19										
20	Patio Walkway-raise and level-Alden Bennett			2014	2,742	183	15	183		1,113
21										
22	Sprinkler, Fire Work - ALDBEN			2015	10,015	401	25	401		2,339
23										
24	Replace Tile in Shower Room - ALDBEN			2016	5,242	134	39	134		581
25										
26	Replace Tile in Shower Room - ALDBEN			2017	6,240	160	39	160		613
27	Replace Tile in Shower Room - ALDBEN			2017	8,905	228	39	228		855
28										
29	Fire System Repairs - DEDRES - Fire System			2018	18,000	3,600	5	3,600		10,500
30	Repair Dormers - ALDBEN - Roof			2018	6,900	690	10	690		1,610
31										
32	Control Panel - ALTCAT - Generator			2020	2,713	317	5	317		317
33										
34										
35										
36										

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Adj for ABC related party profit	2011	86	6		6		63	37
38	Adj for ABC related party profit	2014	(5)	(1)		(1)		(5)	38
39	Adj for ABC related party profit	2015	(19)	(2)		(2)		(19)	39
40	Adj for ABC related party profit	2016	(33)	(2)		(2)		(33)	40
41	Adj for ABC related party profit	2017	(12)	(2)		(2)		(12)	41
42	Adj for ABC related party profit	2018	(21)	(2)		(2)		(21)	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,036,885	\$ 30,888		\$ 30,888	\$	\$ 555,919	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning:

01/01/2020 Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,036,885	\$ 30,888		\$ 30,888	\$	\$ 555,919	1
2	Forum Prof Ctr: Remodeling	1979	14,770		20			14,770	2
3	Forum Prof Ctr: Build Improv - multiple	1980	28,765		15			28,765	3
4	Forum Prof Ctr: Tennant Improv	1986	908		13			908	4
5	Forum Prof Ctr: AMS remodel	1990	6,169		10			6,169	5
6	Forum Prof Ctr: Roof	1994	3,254		16			3,254	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,147		16			1,147	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,812		10			1,812	8
9	Forum Prof Ctr: Remodel/electrical	2001	706		7			706	9
10	Forum Prof Ctr: bathroom remodel	2002	624		5			624	10
11	Forum Prof Ctr: remodel suites/etc.	2003	803		9			803	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,471		7			2,471	12
13	Forum Prof Ctr: Suite renovation	2005	2,383		10			2,383	13
14	Forum Prof Ctr: Superior installations, etc.	2006	119		4			119	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	479		7			479	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	412		7			412	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	838		10			838	17
18	Forum Prof Ctr: Building Renovations	2010	1,427		5			1,427	18
19	Forum Prof Ctr: Building Renovations	2011	4,480	357	10	357		3,966	19
20	Forum Prof Ctr: Building Renovations	2012	272	2	15	2		262	20
21	Forum Prof Ctr: Building Renovations	2013	408	24	7	24		408	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	415	42	10	42		260	22
23	Forum Prof Ctr: Park.Lot/Signs/Lighting/HVAC	2015	338	4	10	4		298	23
24	Forum Prof Ctr: Suite 116 walls/lighting/floor, renov.	2017	952	106	13	106		388	24
25	Forum Prof Ctr: Suite 140 Renov: fire sprinkler piping,drywall,duc	2018	20,628	1,423	15	1,423		3,563	25
26	Forum Prof Ctr: floors, walls,plumbing,hvac,carpentry	2019	1,239	127	10	127		212	26
27	Forum Prof Ctr: PktLot,door frames,windows	2020	541	32	3-10	32		32	27
28	Alden Mgt Servs: Remodel suites	1993	6,577		7			6,577	28
29	Alden Mgt Servs: Remodel suites	2002	274		13			274	29
30	Alden Mgt Servs: Remodel suites	2003	5,946		8			5,946	30
31	Alden Mgt Servs: MotorControl Board	2014	81		15			81	31
32	Alden Mgt Servs: Suite 140 Renov:walls,flooring,electrical,ceiling,	2018	37,755	2,579	15	2,579		6,417	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,183,878	\$ 35,584		\$ 35,584	\$	\$ 651,690	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$123,519	\$9,494	\$9,494	\$	various	\$53,155	71
72	Current Year Purchases	20,334	516	516		various	516	72
73	Fully Depreciated Assets	237,324	1,291	1,291		various	237,324	73
74								74
75	TOTALS	\$381,177	\$11,301	\$11,301	\$		\$290,995	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus Transfer from AMS	Bus	2001	\$16,646	\$	\$	\$	5	\$16,646	76
77	related party-AMS	various	1998-2004	3,802				3	3,802	77
78										78
79										79
80	TOTALS			\$20,448	\$	\$	\$		\$20,448	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,736,37181
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$46,88582
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$46,88583
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$963,13385

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Related party - cost is eliminated
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

X

NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:YES

X

NOTerms:*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES

X

NO
16. Rental Amount for movable equipment:\$1,422Description:copy machine GL 6861 and equipment lease GL 6859
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Related Party - Pg 6A		\$173.42	\$2,081	17
18					18
19	Auto Lease - GL 6890		0.00	0	19
20					20
21	TOTAL		\$173.42	\$2,081	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

10. Effective dates of current rental agreement:

Beginning12/02/1996
Ending11/30/2036

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/21	\$Varies
13.	12/31/22	\$Varies
14.	12/31/23	\$Varies

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nursing on site

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed			Contract	Total
1	Community College Tuition	\$	\$			\$	\$
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$			\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See PG16A	# of prescripts				3,421		3,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See PG16A	39-1, 39-3, if any					2,153		2,153	13
14	TOTAL			\$		\$	\$ 5,574		\$ 5,574	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

				Page 16
				Col 5: PT,OT, & ST
				Col 6: Supplies
XIV. Special Services (Direct Cost)				
Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.	
1.	OT	39-3	To Col 5	
2.	ST	39-3	To Col 5	
3.				
4.	PT	39-3	To Col 5	
5.				
6.				
7.				
8.	Pharmacy Supplies per GL			3,491.00
	Manual Input from Related Party- Forum Drugs & Vaccinations			(70.00)
				From Page 6C. Ln 39, Col 8 Drug Items
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	3,421.00
10.				
11.				
12.	Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12.	Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00
Total Exceptional Care (Line 12, Col 8)				0.00
13.	Other: Transport. Specialist (6001-100-019)		See Pg 16A	
13.	Col 5: Manual Input: Related Party - CPT		To Col 5	From Page 6D, Col 8 (Except DD homes)
Other				4,580.00
Manual Input: Related Party - Prism				(2,460.00)
Manual Input: Related Party FECII - I.V.				From Page 6B/Ln 39 items, Col 8
Manual Input: Related Party FECII - Wound Care-Products Only				From Page 6C/Ln 39 items for IV, Col 8
Oxygen, from reclass worksheet (Pg 4A)				(1.00)
				From Page 6C/Ln 39 items for Wound Care Products, Col 8
				34.00
13.	Col 6: Supplies Total		To Col 6	2,153.00
13.	Total Line 13, Column 8			2,153.00
14.	Total			5,574.00
				=====

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	4,157	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (250))	158,833	158,833	3
4	Supply Inventory (priced at)	42,003	42,003	4
5	Short-Term Investments			5
6	Prepaid Insurance		5,693	6
7	Other Prepaid Expenses	7,860	7,860	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 208,696	\$ 218,546	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		141,874	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	65,077	111,763	15
16	Equipment, at Historical Cost	90,341	344,332	16
17	Accumulated Depreciation (book methods)	(105,222)	(857,735)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		16,294	21
22	Other Long-Term Assets (specify):		23,769	22
23	Other(specify): Due From Affiliates	2,425,460	2,432,483	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,475,656	\$ 3,147,641	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,684,352	\$ 3,366,187	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 234,745	\$ 236,145	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,609	7,609	28
29	Short-Term Notes Payable		26,700	29
30	Accrued Salaries Payable	98,574	98,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,503	29,503	31
32	Accrued Real Estate Taxes(Sch.IX-B)		17,346	32
33	Accrued Interest Payable		2,117	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr. Exp/Ins, Due to IDPA, Sales Tax/Pro	797,313	797,313	36
37	Due to Affiliates - Current	22,271	22,271	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,190,015	\$ 1,237,578	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		989,680	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	FICA - Deferred	19,664	19,664	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 19,664	\$ 1,009,344	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,209,679	\$ 2,246,922	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,474,673	\$ 1,119,265	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,684,352	\$ 3,366,187	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,372,396	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustment recorded	(62,268)	3
4	after prior year submitted and cost allocations.		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,310,128	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	164,545	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 164,545	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,474,673	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,678,096	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,678,096	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Page19A</u>	355,926	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 355,926	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,034,022	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	275,798	31
32	Health Care	663,999	32
33	General Administration	368,258	33
	B. Capital Expense		
34	Ownership	109,005	34
	C. Ancillary Expense		
35	Special Cost Centers	362,639	35
36	Provider Participation Fee	89,778	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,869,477	40
41	Income before Income Taxes (line 30 minus line 40)**	164,545	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 164,545	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,678,096	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Hospice		47
48	Other-(specify) Insur,Vets,Charity/Sales Allows		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,678,096	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet avail. If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
GL 461500-100-000 Day Training Income	\$ 354,568
GL 498500-100-000 Gain on Sale of Assets (related to prior yr, not	\$ 1,358

Line 28 Total: 355,926

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,110	2,374	85,588	36.05	3
4	Licensed Practical Nurses	2,255	2,419	90,236	37.30	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	512	520	11,858	22.80	9
10	Activity Assistants	514	520	9,047	17.40	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,797	5,030	89,885	17.87	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,361	1,580	25,665	16.24	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	518	520	21,047	40.48	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	298	324	5,802	17.91	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	20,079	22,194	416,216	18.75	30
31	Medical Records					31
32	Other Health Care Behavioral Special	345	347	11,401	32.86	32
33	Other(specify) Facility Manager	1,016	1,024	25,144	24.55	33
34	TOTAL (lines 1 - 33)	33,805	36,852	\$ 791,889 *	\$ 21.49	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 4,910	1-3	35
36	Medical Director		3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant		384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		180	11-3	44
45	Social Service Consultant		700	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,774		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Jennifer Kristy Moran	Executive Director	0	\$ 0	Workers' Compensation Insurance		\$ 23,918	IDPH License Fee		\$		
allocated		0		Unemployment Compensation Insurance		2,223	Advertising: Employee Recruitment		286		
		0		FICA Taxes		60,196	Health Care Worker Background Check		0		
		0		Employee Health Insurance		35,382	(Indicate # of checks performed)				
		0		Employee Meals		8,607	Patient Background Checks		0		
		0		Illinois Municipal Retirement Fund (IMRF)*			Surety Bond		200		
		0		Insurance (Dental, Life, Vision)		634	Corporate Annual Fee		77		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Relations		1,201	BMI Broadcast Radio		79		
(List each licensed administrator separately.)				Misc. Payroll		281	Center for Developmental Disabilities/Collaborative		1,254		
B. Administrative - Other				Drug/Covid Testing		842	Related party-AMS		148		
Description				Vaccinations		101	Less: Public Relations Expense		()		
				401K Match		517	Non-allowable advertising		()		
				Related Party - Forum		(101)	Yellow page advertising		()		
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 133,801	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,044		
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)											
C. Professional Services				Description		Line #	Amount		Amount		
Vendor/Payee	Type		Amount								
Alden Management Services	consulting fee		\$ 90,370				Out-of-State Travel		\$		
Mid Cap	Legal Fees		99								
AMS Allocated Legal Fees	Legal Fees		25,200								
Mid Cap	Accounting Fees		550				In-State Travel				
Baker Tilly	Accounting Fees		3,640								
							Related party-AMS		125		
							Seminar Expense				
							Wisconsin Health Care Association Fall Conference		68		
							Ill. Assoc. of Rehab Facilities Virtual Annual Meeting		81		
							Entertainment Expense		()		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)				
(For legal fee disclosure, see page 39 of instructions)							TOTAL		\$ 274		

*** Attach copy of IMRF notifications**

****See instructions.**

Alden of Old Town West	PG 21A
Legal Fee Support	
2020	
Legal Fees Reported on Pg 21, Section C:	\$ 25,299.00
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22	-
Non-allowable legal fees, if any, deducted on	(25,200.00)
- AMS Allocated Legal Fees: GL 680600-100-003	
+ Add Back voided invoice of prior year, if any	
Allowable Legal Fees	<u>\$ 99.00</u>

In Detail:		
Vendor Name	Invoice Date	Amount
Mid-Cap	6/20,7/20,10/20	99.00
TOTAL ALLOWABLE LEGAL FEES		<u>99.00</u>

Vendor Name	Invoice Date	Amount
TOTAL Collection-NOT ALLOWABLE LEGAL FEES		<u>-</u>

Vendor Name	Invoice Date	Amount
AMS Allocated Legal Fees	1/1/20- 12/31/20	25,200.00
TOTAL Allocated Legal Fees		<u>25,200.00</u>

Total Legal Cost	<u>25,299.00</u>
------------------	------------------

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

HAB:Yes:RN/LPN:No

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

The Center for Developmental Disabilities - \$1254

(3)

Did the nursing home make political contributions or payments to a political action organization?

yes

If YES, have these costs been properly adjusted out of the cost report?

yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

7.5 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 10,561

Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

x

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

x

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 89,778

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

no

If YES, attach an explanation of the allocation.

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

no

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 8,607

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ no

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

no

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

no

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

g. Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

no

Firm Name:

N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

yes

Attach invoices and a summary of services for all architect and appraisal fees.